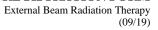


External Beam Radiation Therapy (09/19)

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|------------|--------|-----------|
| General | Intori | mation |
| viciici ai | | 114111111 |

| First Name: | Last Name: | S | Suffix: (Ph.D., M.S., B.S., etc.) |
|---|--|--|--------------------------------------|
| Mailing Address: | | | |
| City: | State: | ZIP: | |
| Primary Phone Number: | | Cell Phone Number: | |
| Email Address: | | | |
| Primary Facility of Employment: | | | |
| Facility Address: (Street, City, State, 2 | ZIP): | | |
| (If emplo | oyed at multiple facilities, please comp | lete Appendix A to include eac | h facility) |
| | | | |
| | on cognized Certifying Body | | (Check applicable Pathway |
| Path One: Nationally-Rec | | h.D. Degree) | (Check applicable Pathway |
| | cognized Certifying Body Craining and Experience (Masters/P | h.D. Degree) | (Check applicable Pathway |
| Path One: Nationally-Red Path Two: Degree Plus T Path Three: Alternative St | cognized Certifying Body Craining and Experience (Masters/P | ody | |
| Path One: Nationally-Red Path Two: Degree Plus T Path Three: Alternative St Path One: Nationally-Red Board Certification | cognized Certifying Body Training and Experience (Masters/Pandard Recognized Certifying B | Area of Certific | cation |
| Path One: Nationally-Red Path Two: Degree Plus T Path Three: Alternative St Path One: Nationally-Red | cognized Certifying Body Craining and Experience (Masters/Pitandard Recognized Certifying B | Area of Certific | cation 7 |
| Path One: Nationally-Red Path Two: Degree Plus T Path Three: Alternative St Path One: Nationally-Red Board Certification American Board of Radiological Path One: Nationally-Red American Board of Radiological Path One: Nationally-Red American Board of Radiological Path One: Nationally-Red American Board of Radiological Path One: Nationally-Red Degree Plus T | cognized Certifying Body Craining and Experience (Masters/P sandard Recognized Certifying B ogy (ABR) rd of Radiology (AOBR) | Area of Certification Radiology Therapeut | cation |
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| Path One: Nationally-Red Path Two: Degree Plus T Path Three: Alternative St Path One: Nationally-Red Board Certification American Board of Radiolo American Osteopathic Board Fellow of the Faculty of Radional | cognized Certifying Body Training and Experience (Masters/P Trai | Area of Certification Radiology Therapeut Radiation | cation / cic Radiology Oncology apy |

ATTACH COPY OF BOARD CERTIFICATION

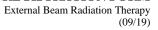




Path Two: Degree Plus Training and Experience

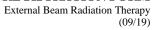
| Description of Training | Location of Training | Clock Hours | Dates of Training |
|---------------------------------------|--------------------------------|--------------|-------------------|
| Radiation physics and instrumentation | | | |
| | | | |
| | | | |
| Radiation protection | | | |
| | | | |
| | | | |
| | | | |
| Mathematics pertaining to the use and | | | |
| measurement of ionizing radiation | | | |
| | | | |
| Radiation biology | | | |
| radiation biology | | | |
| | | | |
| | | | |
| Tota | l Clock Hours (Must be at leas | t 200 hours) | |

| Description of Supervised Work Experience | Location of Work Experience | Clock Hours | Dates of Work Experience |
|---|--------------------------------|---------------|-----------------------------|
| Review of the full calibration measurements and periodic quality assurance checks | • | | • |
| Use of administrative controls to prevent misadministrations (medical events) | | | |
| Evaluation of prepared treatment plans and calculation of treatment times and patient treatment settings | | | |
| Implementing emergency procedures to be followed in event of the abnormal operation of an external beam radiation therapy unit or console | | | |
| Checking and using survey meters | | | |
| Tota | l Clock Hours (Must be at leas | st 500 hours) | |
| Supervising Authorized User Name: | | | |





| Description of Supervised Clinical | Location of Clinical | Years of Clinical | Dates of Clinical |
|---|-----------------------------------|---------------------------|------------------------|
| Experience | Experience | Experience | Experience |
| One (1) Year approved residency program | | | |
| Examining individuals and reviewing their case histories to determine their suitability for external beam radiation therapy treatment and any limitations/contraindications | | | |
| Selecting proper dose and how it is to be administered | | | |
| Calculating external beam radiation therapy doses and collaborating with the Authorized User in the review of patient progress and consideration of need to modify originally prescribed doses and/or treatment plans as warranted by patients' reaction to radiation | | | |
| Post-administration follow-up and review of case histories | | | |
| Total Years of Clinical Experience (Mu | ust be at least one (1) year resi | idency PLUS two (2) years | additional experience) |
| Supervising Authorized User Name: | | | |





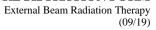
Path Three: Alternative Standard

Kansas Registration Number

Submit documentation of the training and experience of the prospective Authorized User physician for review on a case-by-case basis.

| | r. The preceptor does not have to be the supervising individual as long rience required. If more than one preceptor is necessary to documen |
|--|---|
| Council for Graduate Medical Education or the Command Association and an additional 2 years of full-time wexamining individuals and reviewing their case historical treatment, and any limitations/contraindication calculating the external beam radiation therapy doses patients' progress and consideration of the need to me | has satisfactorily completed a 1-year ency Review Committee for Radiology of the Accreditation aftee on Postdoctoral Training of the American Osteopathic ork experience; has training and experience that includes ites to determine their suitability for external beam radiation on; selecting proper dose and how it is to be administered and collaborating with the authorized user in the review of odify originally prescribed doses and/or treatment plans as administration follow-up and review of case histories. |
| As preceptor, I meet the common qualifications of rendividual seeks authorization. | ecognition for the types of use for which the above-named |
| Name of Preceptor | Signature |
| Phone Number | Date |

Not Approved





Signature of Applicant for Authorized User

| I certify that the information provided on this application is true and Department officials to verify information as needed. | accurate, and I give my permission to the |
|---|---|
| If my contact information changes, I agree to notify KDHE, Bureau of Control Program, 1000 SW Jackson, Suite 330, Topeka, KS 66612-1 kdhe.xray@ks.gov or fax at 785-559-4251. | |
| | |
| Signature of Applicant | Date |
| Submit this completed form and training of Kansas Department of Health and English Bureau of Community Health System Radiation Control Program 1000 SW Jackson, Suite 330 Topeka, KS 66612-1365 Phone: 785-296-1560, Fax: 785-559 Email Address: kdhe.xray@ks | vironment stems 9-4251 |
| KDHE - RADIATION CONTROL PROGR | AM USE ONLY |
| Reviewed By: | THE COST OF LET |
| Date Approved: | |

Comments from Reviewer:

Approved



External Beam Radiation Therapy (09/19)

Appendix A – Facility List

| Facility of Employment: |
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| Facility Address: (Street, City, State, ZIP) |
| Facility Address: (Street, City, State, Zir) |
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| Facility Address: (Street, City, State, ZIP) |
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| Facility Address: (Street, City, State, ZIP) |
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| Facility of Employment: |
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| Facility Address: (Street, City, State, ZIP) |
| Facility Address: (Street, City, State, ZiP) |
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| Facility of Employment: |
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| Facility Address: (Street, City, State, ZIP) |
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| Facility of Employment: |
| Tuently of Employment. |
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| Facility Address: (Street, City, State, ZIP) |
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